Senate Bill No. 260

CHAPTER 529

An act to add Sections 1347.15, 1375.4, 1375.5, and 1375.6 to, and to add and repeal Section 1349.3 of, the Health and Safety Code, relating to health.

[Approved by Governor September 27, 1999. Filed with Secretary of State September 28, 1999.]

LEGISLATIVE COUNSEL'S DIGEST

SB 260, Speier. Health care coverage: risk-bearing organizations: financial solvency.

Existing law regulates health care coverage in a variety of contexts, including (a) the Knox-Keene Health Care Service Plan Act of 1975, under which health care service plans are regulated by the Commissioner of Corporations, (b) the Medi-Cal Act, administered by the State Department of Health Services under which qualified low-income persons are provided with health care services, (c) the Healthy Families Program, administered by the Managed Risk Medical Insurance Board, which arranges for the provision of health care services, including dental and vision care, to eligible children.

Legislation is pending that would transfer the functions and duties of the Department of Corporations and the Commissioner of Corporations, with respect to the regulation of health care service plans, to the Department of Managed Care and the Director of the Department of Managed Care.

This bill would establish the Financial Solvency Standards Board, within the Department of Managed Care, composed of 8 members, one of whom is the Director of the Department of Managed Care and 7 of whom are appointed by the director. It would require the board to take specified actions with regard to financial solvency and standards affecting the delivery of health care services.

The bill, until January 1, 2002, would prohibit a license with waivers or limited license, on or after January 1, 2000, from being issued to any person for provision of, or the arranging, payment, or reimbursement for the provision of, health care services to enrollees of another plan under certain risk-assuming contracts. It would also prohibit any licensed health care service plan, on and after January 1, 2000, from contracting with any person, with certain exceptions, for the assumption of financial risk with respect to certain health care services and any other form of global capitation.

This bill would require every contract between a health care service plan and a risk-bearing organization, as defined, that is issued, amended, renewed, or delivered in this state on or after July 1, 2000,

from including certain provisions concerning the risk-bearing organization's administrative and financial capacity, which would be effective as of January 1, 2001. The bill would require the Director of the Department of Managed Care to adopt regulations on or before June 30, 2000, with respect to, among other things, a process for reviewing or grading risk-bearing organizations based on specified criteria, and would require the director to investigate and take enforcement action against a health care service plan that fails to comply with these prescribed requirements. It would also prohibit a contract between a risk-bearing organization and a health care service plan that is issued, amended, delivered, or renewed in this state on or after July 1, 2000, from including any provision that requires a provider to accept rates or methods of payment specified in contracts with health care service plan affiliates or nonaffiliates unless the provision has been first negotiated and agreed to between the health care service plan and the risk-bearing organization.

Since a violation of the provisions relating to health care service plans is a crime, this bill, by creating new crimes, would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

The people of the State of California do enact as follows:

SECTION 1. Section 1347.15 is added to the Health and Safety Code, to read:

1347.15. (a) There is hereby established in the Department of Managed Care the Financial Solvency Standards Board composed of eight members. The members shall consist of the director, or the director's designee, and seven members appointed by the director. The seven members appointed by the director may be, but are not necessarily limited to, individuals with training and experience in the following subject areas or fields: medical and health care economics; accountancy, with experience in integrated or affiliated health care delivery systems; excess loss insurance underwriting in the medical, hospital, and health plan business; actuarial studies in the area of health care delivery systems; management and administration in integrated or affiliated health care delivery systems; investment banking; and information technology in integrated or affiliated health care delivery systems. The members appointed by the director shall be appointed for a term of three years, but may be removed or reappointed by the director before the expiration of the term.

(b) The purpose of the board is to do all of the following:

(1) Advise the director on matters of financial solvency affecting the delivery of health care services.

(2) Develop and recommend to the director financial solvency requirements and standards relating to plan operations, plan-affiliate operations and transactions, plan-provider contractual relationships, and provider-affiliate operations and transactions.

(3) Periodically monitor and report on the implementation and results of the financial solvency requirements and standards.

(c) Financial solvency requirements and standards recommended to the director by the board may, after a period of review and comment not to exceed 45 days and, notwithstanding Section 1347, be noticed for adoption as regulations as proposed or modified under the rulemaking provisions of the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code). During the director's 45-day review and comment period, the director, in consultation with the board, may postpone the adoption of the requirements and standards pending further review and comment. Within five business days of receipt by the director of the recommendation of the board, the director shall send an information only copy of the recommendations to the members of the Advisory Committee on Managed Care. Nothing in this subdivision prohibits the director from adopting regulations, including emergency regulations, under the rulemaking provisions of the Administrative Procedure Act.

(d) Except as provided in subdivision (e), the board shall meet at least quarterly and at the call of the chair. In order to preserve the independence of the board, the director shall not serve as chair. The members of the board may establish their own rules and procedures. All members shall serve without compensation, but shall be reimbursed from department funds for expenses actually and necessarily incurred in the performance of their duties.

(e) During the two years from the date of the first meeting of the board, the board shall meet monthly in order to expeditiously fulfill its purpose under subparagraphs (A) and (B) of paragraph (1) of subdivision (b).

(f) For purposes of this section, ''board'' means the Financial Solvency Standards Board.

SEC. 2. Section 1349.3 is added to the Health and Safety Code, to read:

1349.3. (a) On or after January 1, 2000, no license with waivers or limited license shall be issued to any person, including a provider or an affiliate of a provider, for the provision of, or the arranging, payment, or reimbursement for the provision of, health care services to enrollees of another plan under a contract or other arrangement whereby the person assumes financial risk for the provision of at least

both physician services and hospital inpatient and ambulatory care services to the enrollees of the plan with which the person proposes to contract or make an arrangement. On and after January 1, 2000, no licensed health care service plan shall contract with any person, other than a licensed health care service plan or licensed health care service plan with waivers, for the assumption of financial risk with respect to the provision of both institutional and noninstitutional health care services and any other form of global capitation. Health care service plans with waivers or risk-bearing organizations, as defined in subdivision (g) of Section 1375.4, may contract with self-insured businesses if the self-insured business does no marketing to the general public.

(b) An applicant for a license with waivers or a limited license that has an application on file with the director on August 1, 1999, shall be entitled to a refund of the application filing fee paid as of January 1, 2000.

(c) This section shall remain in effect only until January 1, 2002, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2002, deletes or extends that date.

SEC. 3. Section 1375.4 is added to the Health and Safety Code, to read:

1375.4. (a) Every contract between a health care service plan and a risk-bearing organization that is issued, amended, renewed, or delivered in this state on or after July 1, 2000, shall include provisions concerning the following, as to the risk-bearing organization's administrative and financial capacity, which shall be effective as of January 1, 2001:

(1) A requirement that the risk-bearing organization furnish financial information to the health care service plan or the plan's designated agent and meet any other financial requirements that assist the health care service plan in maintaining the financial viability of its arrangements for the provision of health care services in a manner that does not adversely affect the integrity of the contract negotiation process.

(2) A requirement that the health care service plan disclose information to the risk-bearing organization that enables the risk-bearing organization to be informed regarding the financial risk assumed under the contract.

(3) A requirement that the health care service plans provide payments of all risk arrangements, excluding capitation, within 180 days after close of the fiscal year.

(b) In accordance with subdivision (a) of Section 1344, the director shall adopt regulations on or before June 30, 2000, to implement this section which shall, at a minimum, provide for the following:

(1) (A) A process for reviewing or grading risk-bearing organizations based on the following criteria:

(i) The risk-bearing organization meets criterion 1 if it reimburses, contests, or denies claims for health care services it has provided, arranged, or for which it is otherwise financially responsible in accordance with the timeframes and other requirements described in Section 1371 and in accordance with any other applicable state and federal laws and regulations.

(ii) The risk-bearing organization meets criterion 2 if it estimates its liability for incurred but not reported claims pursuant to a method that has not been held objectionable by the director, records the estimate at least quarterly as an accrual in its books and records, and appropriately reflects this accrual in its financial statements.

(iii) The risk-bearing organization meets criterion 3 if it maintains at all times a positive tangible net equity, as defined in subdivision (e) of Section 1300.76 of Title 10 of the California Code of Regulations.

(iv) The risk-bearing organization meets criterion 4 if it maintains at all times a positive level of working capital (excess of current assets over current liabilities).

(B) A risk-bearing organization may reduce its liabilities for purposes of calculating tangible net equity, pursuant to clause (iii) of subparagraph (A), and working capital, pursuant to clause (iv) of subparagraph (A), by the amount of any liabilities the payment of which is guaranteed by a sponsoring organization pursuant to a qualified guarantee. A sponsoring organization is one that has a tangible net equity of a level to be established by the director that is in excess of all amounts that it has guaranteed to any person or entity. A qualified guarantee is one that meets all of the following:

(i) It is approved by a board resolution of the sponsoring organization.

(ii) The sponsoring organization agrees to submit audited annual financial statements to the plan within 120 days of the end of the sponsoring organization's fiscal year.

(iii) The guarantee is unconditional except for a maximum monetary limit.

(iv) The guarantee is not limited in duration with respect to liabilities arising during the term of the guarantee.

(v) The guarantee provides for six months' advance notice to the plan prior to its cancellation.

(2) The information required from risk-bearing organizations to assist in reviewing or grading these risk-bearing organizations, including balance sheets, claims reports, and designated annual, quarterly, or monthly financial statements prepared in accordance with generally accepted accounting principles, to be used in a manner, and to the extent necessary, provided to a single external party as approved by the director to the extent that it does not adversely affect the integrity of the contract negotiation process between the health care service plan and the risk-bearing organizations.

(3) Audits to be conducted in accordance with generally accepted auditing standards and in a manner that avoids duplication of review of the risk-bearing organization.

(4) A process for corrective action plans, as mutually agreed upon by the health care service plan and the risk-bearing organization and as approved by the director, for cases where the review or grading indicates deficiencies that need to be corrected by the risk-bearing organization, and contingency plans to ensure the delivery of health care services if the corrective action fails. The corrective action plan shall be approved by the director and standardized, to the extent possible, to meet the needs of the director and all health care service plans contracting with the risk-bearing organization. If the health care service plan and the risk-bearing organization are unable to determine a mutually agreeable corrective action plan, the director shall determine the corrective action plan.

(5) The disclosure of information by health care service plans to the risk-bearing organization that enables the risk-bearing organization to be informed regarding the risk assumed under the contract, including:

(A) Enrollee information monthly.

(B) Risk arrangement information, information pertaining to any pharmacy risk assumed under the contract, information regarding incentive payments, and information on income and expenses assigned to the risk-bearing organization quarterly.

(6) Periodic reports from each health care service plan to the director that include information concerning the risk-bearing organizations and the type and amount of financial risk assumed by them, and, if deemed necessary and appropriate by the director, a registration process for the risk-bearing organizations.

(7) The confidentiality of financial and other records to be produced, disclosed, or otherwise made available, unless as otherwise determined by the director.

(c) The failure by a health care service plan to comply with the contractual requirements pursuant to this section shall constitute grounds for disciplinary action. The director shall, as appropriate, within 60 days after receipt of documented validation from a risk-bearing organization, investigate and take enforcement action against a health care service plan that fails to comply with these requirements and shall periodically evaluate contracts between health care service plans and risk-bearing organizations to determine if any audit, evaluation, or enforcement actions should be undertaken by the department.

(d) The Financial Solvency Standards Board established in Section 1347.1 shall study and report to the director on or before January 1, 2001, regarding all of the following:

(1) The feasibility of requiring that there be in force insurance coverage commensurate with the financial risk assumed by the risk-bearing organization to protect against financial losses.

(2) The appropriateness of different risk-bearing arrangements between health care service plans and risk-bearing organizations.

(3) The appropriateness of the four criteria specified in paragraph (1) of subdivision (b).

(e) This section shall not apply to specialized health care service plans.

(f) For purposes of this section, ''provider organization'' means a medical group, independent practice association, or other entity that delivers, furnishes, or otherwise arranges for or provides health care services, but does not include an individual or a plan.

(g) (1) For the purposes of this section, a ''risk-bearing organization'' means a professional medical corporation, other form of corporation controlled by physicians and surgeons, a medical partnership, a medical foundation exempt from licensure pursuant to subdivision (l) of Section 1206, or another lawfully organized group of physicians that delivers, furnishes, or otherwise arranges for or provides health care services, but does not include an individual or a health care service plan, and that does all of the following:

(A) Contracts directly with a health care service plan or arranges for health care services for the health care service plan's enrollees.

(B) Receives compensation for those services on any capitated or fixed periodic payment basis.

(C) Is responsible for the processing and payment of claims made by providers for services rendered by those providers on behalf of a health care service plan that are covered under the capitation or fixed periodic payment made by the plan to the risk-bearing organization. Nothing in this subparagraph in any way limits, alters, or abrogates any responsibility of a health care service plan under existing law.

(2) Notwithstanding paragraph (1), risk-bearing organizations shall not be deemed to include a provider organization that meets either of the following requirements:

(A) The health care service plan files with the department consolidated financial statements that include the provider organization.

(B) The health care service plan is the only health care service plan with which the provider organization contracts for arranging or providing health care services and, during the previous and current fiscal years, the provider organization's maximum potential expenses for providing or arranging for health care services did not exceed 115 percent of its maximum potential revenue for providing or arranging for those services.

(h) For purposes of this section, ''claims'' include, but are not limited to, contractual obligations to pay capitation or payments on a managed hospital payment basis.

SEC. 4. Section 1375.5 is added to the Health and Safety Code, to read:

1375.5. (a) Except as provided in subdivision (b), no contract between a risk-bearing organization and a health care service plan that is issued, amended, delivered, or renewed in this state on or after July 1, 2000, shall include any provision that requires the risk-bearing organization to be at financial risk for the provision of health care services, unless the provision has first been negotiated and agreed to between the health care service plan and the risk-bearing organization.

(b) Notwithstanding subdivision (a), this section shall not prevent a risk-bearing organization from accepting the financial risk specified in subdivision (a) pursuant to a contract that meets the requirements of Section 1375.4.

SEC. 5. Section 1375.6 is added to the Health and Safety Code, to read:

1375.6. No contract between a risk-bearing organization and a health care service plan that is issued, amended, delivered, or renewed in this state on or after July 1, 2000, shall include any provision that requires a provider to accept rates or methods of payment specified in contracts with health care service plan affiliates or nonaffiliates unless the provision has been first negotiated and agreed to between the health care service plan and the risk-bearing organization.

SEC. 6. For purposes of Sections 1347.1, 1349.3, 1375.4, 1375.5, and 1375.6, until the Department of Managed Care and the position of the Director of the Department of Managed Care is established by legislative enactment or Executive order by July 1, 2000, the terms ''department'' and ''director'' shall mean the Department of Corporations and the Commissioner of Corporations, respectively.

SEC. 7. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

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